Oversight Division

Committee On Legislative Research

PROGRAM EVALUATION

MEDICAID FRAUD PROGRAM
FOLLOW-UP

Program Evaluation
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FOLLOW-UP

Prepared for the Committee on Legislative Research
by the Oversight Division

Mickey Wilson, CPA, Director
Review Team: Barb Glover, CPA, Team Leader, Wayne Blair, Ross Strope

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COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT SUBCOMMITTEE

THE COMMITTEE ON LEGISLATIVE RESEARCH, Oversight Division, is an agency of the Missouri General Assembly as established in Chapter 23 of the Revised Statutes of Missouri. The programs and activities of the State of Missouri cost approximately $19.2 billion annually. Each year the General Assembly enacts laws which add to, delete or change these programs. To meet the demands for more responsive and cost effective state government, legislators need to receive information regarding the status of the programs which they have created and the expenditure of funds which they have authorized. The work of the Oversight Division provides the General Assembly with a means to evaluate state agencies and state programs.

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Members of the General Assembly:

The Joint Committee on Legislative Research adopted a resolution in May 2004, directing the Oversight Division to perform a follow-up program evaluation of the Medicaid Fraud Program to determine and evaluate program performance in accordance with program objectives, responsibilities, and duties as set forth by statute or regulation.

The report includes Oversight's comments on internal controls, compliance with legal requirements, management practices, program performance and related areas. We hope this information is helpful and can be used in a constructive manner for the betterment of the state program to which it relates. You may request a copy of the report from the Oversight Division by calling 751-4143.

Respectfully,

Representative Rod Jetton
Chairman

EXECUTIVE SUMMARY

Missouri's Medicaid program is administered by the Department of Social Services – Division of Medical Services. In Fiscal Year 2004, the Medicaid program served more than 815,000 Missouri residents, or approximately 14.5 percent of the State's population.

The Medicaid program is jointly financed by the federal government and the state government. Medicaid expenditures for all services were approximately $4.9 billion in Fiscal Year 2004, of which 60 percent was federally funded and 40 percent was state funded.

The State of Missouri processed approximately 78 million Medicaid claims in Fiscal Year 2004 from approximately 35,000 providers. The magnitude of expenditures and volume of services of the Medicaid programs increase the risk of Medicaid fraud.

Oversight reviewed the Medicaid Fraud Program for the period of July 1, 1999 through June 30, 2004. The review included a review of the Department of Social Services – Division of Medical Services – Program Integrity Unit as well as a review of the Office of the Attorney General – Medicaid Fraud Control Unit.

Oversight noted the Office of the Attorney General is not maximizing federal funding for the Medicaid Fraud Control Unit (MFCU). The MFCU expended approximately $125,000 more of state general revenue funds than the required match for the federal funding for the evaluation period. Oversight believes the Office of the Attorney General should review the MFCU expenditures to ensure the state match requirement is not exceeded. Oversight also believes the Office of the Attorney General should investigate whether amended financial information could be filed with the federal government to recoup the overspending of state general revenue funds.

Oversight noted the Office of the Attorney General did not fully staff the Medicaid Fraud Control Unit (MFCU), possibly resulting in decreased collections and loss of federal matching funds for staff. The understaffing of the MFCU has resulted in lapsed federal and general revenue funds annually. Oversight believes the Office of the Attorney General should fully staff the MFCU in an effort to improve the timeliness, prosecution, and collections of Medicaid fraud cases.

Oversight noted the Department of Social Services – Division of Medical Services – Program Integrity Unit (PI) may not be adequately trained in fraud prevention and detection. Although PI personnel received ongoing training, PI appears to be lacking in providing training on identifying potential fraudulent activity. Oversight believes the Department of Social Services – Division of Medical Services should provide training in fraud detection and prevention for the PI Unit. Oversight believes this training should include cross-training with the Office of the Attorney General – Medicaid Fraud Control Unit.

Oversight noted the Medicaid payment system allows providers to receive payments for billing more than 24 hours in one day. Oversight believes the system should include controls to

eliminate overpayments before the payments are made. This would allow Program Integrity and the Medicaid Fraud Control Unit to concentrate their resources on the detection and prevention of Medicaid fraud.

Oversight noted the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) is not requesting reimbursements for all investigation and prosecution costs from Medicaid providers convicted of fraud as allowed by statute. In addition, the calculation of the prosecution costs is not documented in the case files maintained by the MFCU. Oversight believes the Office of the Attorney General should pursue the reimbursement of prosecution and investigation costs from those convicted of Medicaid fraud. Oversight also believes the MFCU should better document the calculation of these costs.

Oversight noted the Department of Social Services – Division of Budget and Finance is not depositing Medicaid restitution receipts and prosecution cost reimbursements received into the appropriate funds. Oversight believes the Department of Social Services should deposit restitution receipts into the Medicaid Fraud Reimbursement Fund and investigation and prosecution reimbursements into the Medicaid Fraud Prosecution Revolving Fund.

Oversight noted the Department of Social Services strategic plan does not include annual goals, objectives, or mention of a fraud detection and prevention program. Oversight believes the Department of Social Services should include strategies that identify weaknesses in current program operation, integrate fraud and abuse fighting activity, and close gaps that permit inappropriate payments. Oversight also believes these strategies should be updated annually.

Oversight noted the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) does not maintain written policy and procedure manuals. Oversight believes the MFCU should compile a written policy and procedures guide or operations manual. This would be helpful in training new staff and would help insure continuity of the Unit in the event of staffing turnover.

Oversight noted the Department of Social Services – Division of Medical Services (DMS) has not implemented recommendations made by the Centers for Medicare and Medicaid Services (CMS). CMS recommended the DMS periodically re-enroll its in-state Medicaid providers. Oversight believes the DMS should follow the recommendations of the DMS. Periodically re-enrolling providers would help ensure providers are held to any legislation or program policy that may have been implemented since the providers' initial enrollment.

The Oversight Division did not audit departmental financial statements and accordingly, does not express an opinion on them.

Mickey Wilson, CPA
Director

Chapter 1 – Introduction

Purpose

The Joint Committee on Legislative Research directed the Oversight Division to conduct a follow-up program evaluation of the Medicaid Fraud Program within the Department of Social Services and the Office of the Attorney General. The evaluation review had the following components: to determine whether the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) and the Department of Social Services – Division of Medical Services (DMS) implemented Oversight's recommendations from the February 2000 report, including whether Medicaid fraud cases referred to the MFCU are promptly investigated, whether the MFCU requests investigation and prosecution costs from Medicaid providers convicted of fraud, whether the MFCU is fully staffed to maximize collections and federal matching funds, whether Medicaid restitution receipts and prosecution reimbursements are deposited into the appropriate funds, and whether the DMS actively pursues and recovers inappropriate payments.

Background

The Missouri Medicaid Program

Medicaid is health insurance that helps many people who cannot afford medical care pay for some or all of their medical bills. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to individuals; instead, it sends payment directly to health care providers. The Medicaid program provides medical services to eligible adults, children, and families, based on income level and medical or physical conditions. The Medicaid program is jointly financed by the federal government and the state government. Missouri's Medicaid program is administered by the Department of Social Services – Division of Medical Services (DMS).

In Fiscal Year 2004, the Medicaid program served more than 815,000 Missouri residents, or 14.5 percent of the State's population. Medicaid expenditures for all services were approximately $4.9 billion in Fiscal Year 2004, of which 60 percent was federally funded and 40 percent was state funded. Medicaid expenditures have also grown during the past ten years, more than doubling during the ten-year period from Fiscal Year 1995 ($2.1 billion) to Fiscal Year 2004 ($4.9 billion). The attached schedule (Appendix I) details the growth in Medicaid expenditures over the past eleven years.

The State of Missouri processed approximately 78 million Medicaid claims in Fiscal Year 2004

from the approximately 35,000 providers. The magnitude of expenditures and volume of services of the Medicaid programs increase the risk of Medicaid fraud. Fraud is defined by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit. Some examples of fraudulent practices committed by Medicaid providers include billing for services, drugs, equipment, or supplies not provided or not needed. Providers have also been found to bill for more expensive procedures than were actually provided to increase their Medicaid reimbursement. Another method of defrauding Medicaid is by "unbundling" and billing for individual services.

In the State of Missouri, the Program Integrity (PI) unit within the DMS plays an important role in Medicaid fraud detection and prevention. PI reviews claims from approximately 80 providers per quarter for providers and beneficiaries who deviate from established service utilization norms. These deviations are identified through various "exception" reports. In addition, PI reviews complaints and referrals received from a variety of sources, including providers, beneficiaries, other DMS staff, consultants, or other agencies.

If the PI review indicates that fraud may be involved, the case is referred to the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU). If the PI review indicates an erroneous payment, the unit sends the provider a notification letter. PI then recovers the overpayment and requests a corrective action plan for the provider, initiates provider education, or pursues administrative sanctions, as appropriate. PI identified $1,350,000 of overpayments in Fiscal Year 2004 and collected approximately 78 percent ($1,060,000) of them.

Since Medicaid is an entitlement program, the Department of Social Services – Division of Medical Services (DMS) cannot terminate recipient participation. DMS can only take preventative measures to ensure the recipient does not abuse the system. One such preventative measure is "lock-in," which limits the recipient to one provider or pharmacy, thus eliminating "Doctor Shopping."

The Department of Social Services – Division of Legal Services, Medicaid Investigations Unit (MIU) investigates fraud and abuse committed by recipients against providers. Also, the MIU assists in provider compliance investigations including overpayments, denial of enrollments, and program sanctions. The MIU recommends to DMS administrative actions to be taken. The DMS must actually take the administrative steps necessary for the administrative action.

The MIU reports roughly 200 cases open at any given time. The number of cases the MIU opens in a given year has increased substantially since FY 2000. This is due to increased efficiency and focus in the process used in the selection of possible fraud cases, primarily through computer enhancements which make the identification of possible recipient fraud more efficient and better focused.

Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General investigates and prosecutes cases involving fraud of the Medicaid program by health professionals and abuse or neglect of Medicaid recipients by care givers. The MFCU was originally certified January 1, 1994. The MFCU employed 16 staff members as of June 30, 2004. The MFCU is funded with 75% federal and 25% general revenue funds.

The MFCU receives case referrals from Department of Social Services – Division of Medical Services, Program Integrity and Department of Social Services – Division of Legal Services, Medicaid Investigations Unit. In addition, the MFCU receives case referrals from other state agencies (such as the Department of Health and Senior Services), private citizens, law enforcement agencies, federal agencies, as well as other sources. Complaints and referrals are reviewed to determine if there is prosecutorial merit. Once prosecutorial merit is determined, an active case is opened and assigned to an attorney and investigator for appropriate investigation and legal action. If a complaint or referral is determined to have no prosecutorial merit, no further investigation is conducted and the complaint is closed.

The Missouri Attorney General has no original jurisdiction over Medicaid fraud cases. Therefore, all cases are referred to local prosecutors or to U.S. Attorneys for prosecution. Local prosecutors can prosecute Medicaid fraud cases on their own, request the Attorney General's Office assist with the prosecution, or refer the cases back to the Attorney General's Office for MFCU attorneys to prosecute.

The MFCU collects provider restitution resulting from the cases it investigates. The MFCU collected a total of $8,395,314 in fiscal years 2000 through 2004. Of this total amount, $7,289,285 was generated from national settlements in cases against large national providers (such as pharmaceutical companies, pharmacies, or laboratories). These cases are typically handled by a national task force. The director of Missouri's MFCU is part of the national task force. The non-national settlement cases resulted in court ordered reimbursements totaling $3,245,159 in fiscal years 2000 through 2004. Of this amount, the MFCU collected $1,106,029. The attached chart (Appendix II) details the total collections, the amount of the total that is generated from the national settlements, the other reported collections, and the total amount of court ordered reimbursements resulting from non-national settlement cases.

Oversight reviewed the Missouri Medicaid program's effectiveness in preventing fraud and abuse. Oversight reviewed the program's policies and procedures for preventing and recovering inappropriate payments. Missouri's practices were compared to other states and studies conducted by federal agencies.

Objectives

The program evaluation had the following components: to determine whether the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) and the Department of Social Services – Division of Medical Services (DMS) implemented Oversight's recommendations from the February 2000 report, including whether Medicaid fraud cases referred to the MFCU are promptly investigated, whether the MFCU requests investigation and prosecution costs from Medicaid providers convicted of fraud, whether the MFCU is fully staffed to maximize collections and federal matching funds, whether Medicaid restitution receipts and prosecution reimbursements are deposited into the appropriate funds, and whether the DMS actively pursues and recovers inappropriate payments.

Scope/Methodology

The scope of the evaluation concentrated on the effectiveness and efficiency of the detection and prevention within the Medicaid Fraud Program for the time period of July 1, 1999 through June 30, 2004 and to follow up on the recommendations from Oversight's February 2000 Program Evaluation of the Medicaid Fraud Program. The methodology used by the Oversight Division included tests of samples of transactions and evaluations of management controls to the extent necessary to fulfill evaluation objectives. A primary method used to measure objectives was conducting personal interviews with agency personnel. In addition, the evaluation included performing on-site testing of controls and procedures.

Chapter 2 – Comments

Comment # 1
The Office of the Attorney General is not maximizing federal funding for the Medicaid Fraud Control Unit.

The Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) is funded with federal funds and state general revenue funds. Oversight's evaluation revealed the MFCU expended approximately $125,000 more of state general revenue funds than the required match for the federal funding for fiscal years 2000 through 2004 (See Appendix III). The MFCU was funded with 75 percent federal and 25 percent general revenue funds for these years.

The Office of the Attorney General is not notified of the federal grant award for the MFCU until after the beginning of the federal fiscal year, usually November or December. As a result, state funds must be expended until the federal funds are available for draw down. However, expenditures are not reviewed prior to fiscal year end to ensure the state matching requirement has not been exceeded. As a result, state general revenue funds in excess of the required match were expended in each fiscal year.

Oversight recommends the Attorney General's Office review MFCU expenditures on a regular basis to ensure the state match requirement is not exceeded. In addition, the AGO should investigate whether amended financial information could be filed to recoup the overspending of state general revenue funds.

Comment # 2
The Office of the Attorney General did not fully staff the Medicaid Fraud Control Unit, possibly resulting in decreased collections and loss of federal matching funds for staff.

Oversight's evaluation revealed the MFCU has consistently left appropriated FTE positions unfilled, which has resulted in the underutilization of federal funds. The Office of the Attorney General has requested and received appropriations for 23 FTE to staff the Medicaid Fraud Control Unit (MFCU) during fiscal years 2000 through 2005. However, staff levels have ranged between 11.75 FTE (SFY 2001) and 16.94 FTE (SFY 2003) during this period. The MFCU has not been fully staffed since its inception. The attached chart (Appendix III) details the MFCU staff levels for state fiscal years 2000 through 2004.

The understaffing of the MFCU has reduced the potential for collections and caused the loss of federal matching funds for staff. The understaffing of the MFCU has resulted in lapsed federal and general revenue funds annually. The following chart details the amount of underutilized federal funds and the amount of state funds required to utilize these federal funds for federal fiscal years 2000 through 2003:

Office of the Attorney General - Medicaid Fraud Control Unit
Federal Grant Awarded but Unutilized
For Federal Fiscal Years 2000 through 2004

	Federal Fiscal Year 2000	Federal Fiscal Year 2001	Federal Fiscal Year 2002	Federal Fiscal Year 2003	Federal Fiscal Year 2004
Federal Grant Awarded	$1,536,000	$1,404,000	$1,412,000	$1,388,000	$1,368,000
Actual Federal Funds utilized	$ 665,777	$ 691,310	$ 802,587	$ 748,231	N.A.
Unutilized Federal Funds	$ 870,223	$ 712,690	$ 609,413	$ 639,769	N.A.
State Funds required to Utilize Federal Funds (25%)	$ 290,074	$ 237,563	$ 203,138	$ 213,256	N.A.

Oversight recommends the Office of the Attorney General fully staff the Medicaid Fraud Control Unit in an effort to improve the timeliness, prosecution, and collections of Medicaid fraud cases.

Comment # 3
The Division of Medical Services – Program Integrity Unit may not be adequately trained in fraud prevention and detection.

Oversight reviewed the training log for Program Integrity staff. Although personnel receive ongoing training, much of the training was on the capabilities of the new fraud detection system and the exception reports that this new system could generate. Program Integrity appears to be lacking in providing training on identifying potential fraudulent activity.

Section 42 CFR 432.30 states a state Medicaid plan must provide for a program of training for Medicaid agency personnel. The training should include initial in-service training for newly appointed staff and continuing training opportunities to improve the operation of the program.

One of the Performance Standards for State Medicaid Fraud Control Units developed by the U.S. Office of Inspector General (OIG) is that the Medicaid Fraud Control Unit (MFCU) periodically review its Memorandum of Understanding (MOU) with the single state Medicaid agency and seek amendments to ensure the MOU reflects current law and practice. In meeting this standard, the indicators the OIG will consider include whether the MOU addresses cross-training with the fraud detection staff of the State Medicaid agency.

Program Integrity has requested, but has not received, fraud detection training from the MFCU. Such training would help improve the quality of referrals the MFCU receives from Program Integrity by making Program Integrity more aware of what constitutes Medicaid fraud, how to detect Medicaid fraud, and the MFCU's capabilities.

Oversight recommends the Department of Social Services – Division of Medical Services provide training in fraud detection and prevention for the Program Integrity unit. Oversight recommends the training include cross-training with the Office of the Attorney General's Medicaid Fraud Control Unit.

Comment # 4
The Medicaid payment system allows providers to receive payments for billing more than 24 hours in one day.

The Medicaid payment system does not deny payment to providers for billing more than 24 hours in one day. This allows overpayments to be made which are later identified through exception reports. Once the overpayments are made, Program Integrity (PI) and the Medicaid Fraud Control Unit (MFCU) must use their resources to recoup the overpayments. PI identified $1,350,000 of overpayments in Fiscal Year 2004 and collected approximately 78 percent ($1,060,000) of them.

Oversight's evaluation revealed several instances where exception report parameters identified an unreasonable number of hours billed in one day. In one such instant, an individual provider billed for 44 hours of services in one day. Although the services were billed through four different facility providers, the same individual provider was listed in each instance.

The system should include edits to deny payments to individual providers for billing in excess of a certain number of hours per day. The denial of payments would result in fewer overpayment referrals to the MFCU and would allow the MFCU to concentrate its resources on the detection and prevention of Medicaid fraud.

Oversight recommends PI establish controls to eliminate overpayments before the payments are made. This would allow PI and the MFCU to concentrate their resources on the detection and prevention of Medicaid fraud.

Comment # 5
The Office of the Attorney General – Medicaid Fraud Control Unit is not requesting reimbursements for all investigation and prosecution costs from Medicaid providers convicted of fraud as allowed by statute. In addition, the calculation of the prosecution costs is not documented in the case files maintained by the Medicaid Fraud Control Unit.

Oversight's review of case files and payment receipts revealed some instances where the Medicaid Fraud Control Unit (MFCU) has pursued and been awarded investigative and prosecution costs from those convicted of Medicaid fraud. However, the documentation of the calculation of these costs was not evident in all instances. The MFCU reported investigative and prosecution costs are the last penalties imposed by the courts. In several instances reviewed, the judge denied the award of investigative and prosecution costs. The MFCU does not track the amounts of investigative and prosecution costs requested, denied by the courts, awarded, or collected.

The MFCU is authorized, pursuant to Section 191.905, RSMo, to request reimbursements from the court for investigation and prosecution costs from Medicaid providers convicted of fraud.

Oversight recommends the Office of the Attorney General continue to comply with Section 191.905, RSMo and pursue investigative and prosecution costs from those convicted of Medicaid fraud. Oversight also recommends the MFCU better document the calculation of these costs. In addition, Oversight recommends the MFCU track the amounts of investigative and prosecution costs requested, denied by the courts, awarded, or collected.

Comment # 6
The Department of Social Services – Division of Budget and Finance is not depositing Medicaid restitution receipts and prosecution cost reimbursements received into the appropriate funds.

The Department of Social Services (DOS) – Division of Budget and Finance (BAF) is not depositing Medicaid restitution receipts and prosecution cost reimbursements received into the appropriate funds.

When the Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) receives payment on a settlement agreement, ordered restitution, or investigative and prosecution costs, the MFCU sends the payment to BAF. A transmittal memorandum detailing the statutory authority (Section 191.905, RSMo), amount of the check(s), and the fund(s) into which the check(s) should be deposited accompanies the check(s). BAF signs a receipt acknowledging they received the check(s) and returns this

receipt to MFCU.

Oversight's review revealed numerous transmittals directing BAF to deposit restitution into the Missouri Medicaid Fraud Reimbursement Fund. Oversight's review also revealed several transmittals directing BAF to deposit reimbursement of investigative costs into the Medicaid Fraud Prosecution Revolving Fund. A review of the Fund Activity Reports obtained from the State Treasurer's Office revealed no deposits into the Missouri Medicaid Fraud Reimbursement Fund for Fiscal Years 2000 through 2004. The Medicaid Fraud Prosecution Revolving Fund did not appear on these Fund Activity Reports, indicating this fund has never been used.

Failure to use the Medicaid Fraud Reimbursement Fund and the Medicaid Fraud Prosecution Revolving Fund does not meet the intent of Section 191.905, RSMo. In addition, failure to deposit Medicaid fraud restitutions and prosecution cost reimbursements into the established funds removes clear accounting of the amounts received. By depositing the restitutions and reimbursements into the proper funds, DOS could establish a performance measure for the operations of the Medicaid Fraud Control Unit. Also, failure to deposit monies into the proper funds hinders the General Assembly's annual appropriation review process.

Failure to use the Medicaid Fraud Prosecution Revolving Fund prohibits reimbursement to the prosecuting agency. Any Medicaid restitutions received are not segregated to ensure proper refunds for falsely obtained monies from the federal government and affected state agencies. Medicaid prosecution cost reimbursements are not earmarked for the Attorney General or any prosecuting or circuit attorney who has successfully prosecuted a Medicaid fraud case.

Oversight recommends the Office of the Attorney General and the Department of Social Services work together to utilize the Medicaid Fraud Reimbursement and the Medicaid Fraud Prosecution Revolving Funds that were established in Section 191.905, RSMo by the General

Assembly. Medicaid fraud reimbursements and prosecution cost reimbursements should be deposited into these funds. The Office of the Attorney General should request appropriations from the Medicaid Fraud Prosecution Revolving Fund to reimburse costs associated with the investigation and prosecution of Medicaid Fraud. These funds should be used in the operation of the Medicaid Fraud Control Unit.

Comment # 7
The Department of Social Services – Division of Medical Services strategic plan does not include annual goals, objectives, or mention of a fraud detection and prevention program within the department or division.

Oversight reviewed the Strategic Plans for the Department of Social Services for Fiscal Years 2000 through 2005. The FY 2002 Strategic Plan included strategies that addressed deleting and deterring fraudulent activities within the overall goal of Efficiency and Effectiveness of the Department. The strategies included were to request staff or other resources in an effort to delete and deter fraudulent activities and continue to work with the Attorney General's Medicaid Fraud and Abuse Unit in referring potential cases of Medicaid fraud. The Strategic Plans for the remaining fiscal years did not directly address Medicaid fraud detection and prevention.

Although the Department of Social Services Strategic Plan for Fiscal Year 2002 included strategies that addressed deleting and deterring fraudulent activities, such strategies were not included in the remaining fiscal years.

Oversight recommends DOS include strategies that identify weaknesses in current program operation, integrate fraud and abuse fighting activity, and close gaps that permit inappropriate payments. Oversight recommends this framework be updated annually to reflect changing trends in the detection and prevention of fraud.

Comment # 8
The Office of the Attorney General – Medicaid Fraud Control Unit does not maintain written policy and procedure manuals.

The Medicaid Fraud Control Unit (MFCU) does not currently operate with written policy and procedure manuals or operations manuals. One of the Performance Standards for State Medicaid Fraud Control Units developed by the U.S. Office of Inspector General (OIG) is that the MFCU should establish policies and procedures for its operations. In meeting this standard, one of the indicators that the OIG will consider is whether the MFCU has policy and procedure manuals.

Given the high turnover rate of MFCU staff, a written policy and procedures guide or operations manual would be helpful in training new staff. In addition, a written guide or manual would help ensure continuity in the event of staffing turnover.

Oversight recommends the MFCU compile a written policy and procedures guide or operations manual.

Comment # 9
Department of Social Services – Division of Medical Services has not implemented recommendations made by Centers for Medicare and Medicaid Services.

The U.S. Department of Health and Human Services – Centers for Medicare and Medicaid Services (CMS) conducted a review of Missouri's Medicaid Program Integrity procedures in 2001. CMS made observations/recommendations regarding the Division of Medical Services (DMS) Medicaid provider enrollment. CMS recommended the Division of Medical Services periodically re-enroll its in-state Medicaid providers. According to CMS, out-of-state hospitals in nonbordering states are required to re-enroll annually; however, the State does not otherwise re-enroll its providers. CMS suggested the State consider periodically re-enrolling all participating providers to ensure they are held to any new legislation or program policy that may have been implemented since the providers' initial enrollment.

Oversight recommends the DMS follow the recommendations of the CMS and periodically re-enroll Medicaid providers. Periodically re-enrolling providers would help ensures providers are held to any new legislation or program policy that may have been implemented since their initial enrollment.

Chapter 3 – Status of Prior Comments

Medicaid Fraud Control Unit

Comment # 1
The Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) did not promptly investigate all cases in a timely manner as required by the Memorandum of Understanding between the two agencies.

Oversight recommended the General Assembly encourage the MFCU to adhere to the requirements of the Memorandum of Understanding for reviewing all referrals within 90 days. In addition, when MFCU closes a referral they should notify SURS of the action taken and allow SURS to investigate the case for any administrative actions that could be taken.

Status:

Implemented. The current Memorandum of Understanding states the MFCU will promptly screen all suspected fraud referrals and no longer contains the 90 day window. Oversight's evaluation revealed no instances where the MFCU did not review a referral within 90 days. In most instances, referrals were reviewed within two or three days. Program Integrity is notified when a referral is closed and of any action taken by the MFCU.

Comment # 2
The Office of the Attorney General – Medicaid Fraud Control Unit (MFCU) closed referrals for further investigation but did not refer them back to the Department of Social Services – Division of Medical Services – Surveillance Utilization Review Unit (SURS) for review and follow-up for any overpayments or billing mistakes.

Oversight recommended the General Assembly encourage the MFCU and SURS to adhere to the requirements of the Memorandum of Understanding between the two agencies or amend the Memorandum to reflect current procedures. In addition, when MFCU closes a referral for further investigation, MFCU will notify SURS of the action taken and allow SURS to investigate the case for any administrative actions that need to be taken.

Status:

Implemented. The MFCU notifies Program Integrity when a referral is closed for further investigation and of any action taken by the MFCU.

Comment # 3

The Office of the Attorney General – Medicaid Fraud Control Unit is not requesting reimbursements for all investigation and prosecution costs from Medicaid providers convicted of fraud as allowed by statute. In addition, the calculation of the prosecution costs in not documented in the case files maintained by the Medicaid Fraud Control Unit.

Oversight recommended the Office of the Attorney General comply with Section 191.905, RSMo and pursue cost reimbursements from those convicted of Medicaid fraud.

Status:

Not implemented. See Chapter 2, Comment # 5. The MFCU stated they track the hours and expenses for each case and will ask for a reimbursement in the judgement; but generally, prosecution cost reimbursement is the last judgement to be accepted in the settlement.

Comment # 4

The Office of the Attorney General is not meeting target collections that were used as a basis for creating the Medicaid Fraud Control Unit.

Oversight recommended the Office of the Attorney General retain documentation of fiscal note estimates.

Status:

The MFCU stated the unit met the target collections during fiscal year 2004.

Comment # 5

The Office of the Attorney General did not fully staff the Medicaid Fraud Control Unit, possibly resulting in decreased collections and loss of federal matching funds for staff.

Oversight recommended the Office of the Attorney General fully staff the Medicaid Fraud Control Unit in an effort to improve the timeliness, prosecution, and collections of Medicaid fraud cases.

Status:

Not implemented. See Chapter 2, Comment # 2. The MFCU stated they have never been fully staffed. The MFCU is still authorized for 23 FTE; however, only 16 of the positions are filled at a given time. Therefore, the MFCU lapses appropriations from the Federal Government and the State Government.

Comment # 6

The Office of the Attorney General – Medicaid Fraud Control Unit did not file the 1997 annual report with the Health Care Financing Administration as required by federal regulations. Oversight recommended the MFCU file annual reports in a timely manner in order to ensure continued federal funding.

Status:

Implemented. The MFCU provided a copy of quarterly and annual reports submitted to the U.S. Department of Health and Human Services – Office of Inspector General for fiscal years 2000 through 2004.

Comment # 7

The Office of the Attorney General is not maximizing federal funding for the Medicaid Fraud Control Unit.

Oversight recommended the Attorney General's Office review MFCU expenditures on a regular basis to ensure the state match requirement is not exceeded. In addition, the AGO should investigate whether amended financial information could be filed to recoup the overspending of state general funds.

Status:

Not implemented. See Chapter 2, Comment # 1. The MFCU stated they are still not maximizing federal funding. This is due in part to the difficulty in coordinating the state fiscal year and the federal fiscal year.

Department of Social Services

Comment # 1
The Department of Social Services – Division of Medical Services strategic plan does not include any goals, objectives, or mention of a fraud detection and prevention program within the department or division.

Oversight recommended that DMS develop an overall framework to heighten accountability for fraud detection and prevention in the state medicaid program. The framework should include strategies that identify weaknesses in current program operations, integrates fraud and abuse fighting activities, and closes gaps that permit inappropriate payments. In addition, this framework should be updated annually to reflect changing trends in the detection and prevention of fraud.

Status:

Partially Implemented. See Chapter 2, Comment # 7. The Department of Social Services stated the Department of Social Services, Strategic Plan 2002, Efficiency and Effectiveness of the Department, Objective 9, directly addressed the effort to delete and deter fraudulent activities. Strategies for Objective 8 of the Department's Strategic Plan were provided. Additionally, the Division of Medical Services is developing two new goals for inclusion in the 2006 Department of Social Services Strategic Plan: one to increase cost avoidance, and the other to increase cost savings.

Comment # 2
The Department of Social Services – Division of Medical Services (DMS) requested and received funding for five additional FTE to assist the Medicaid Fraud Control Unit in the Attorneys General's Office but has not filled two of the positions.

Oversight recommended the General Assembly, through the budget and appropriations staff, determine the status for the funding of the positions in regard to appropriations or reduce DMS's core budget by the two positions and corresponding expense and equipment.

Status:

The Department of Social Services stated the FTE were added as a one-time expense for FY 95. For FY 96, funding was continued for four of the FTE but funding was removed, via a core cut, for one of the FTE that was added in the prior year.

DMS could not identify the FTE as being specifically assigned full-time to fraud detection and prevention activities. Instead, there are many staff that perform fraud prevention and detection activities as part of their daily routine. There are 16 staff within the Program Integrity unit who perform preventive procedures to avoid fraud and abuse,

detect abnormal patterns, and refer potential fraud to the Attorney General's Office. In addition, DMS has 18 staff in the Quality Assessment unit and 9 staff from the Pharmacy and Exceptions unit that play critical roles for the division in the prevention of fraud by continuously monitoring, reviewing, and evaluating provider practices. Through maximizing the use of the fourth FTE dollars by spreading it throughout many positions, the division support for Program Integrity related activities far exceeds that gained by a single FTE.

Comment # 3

The Division of Medical Services – Surveillance and Utilization Review Unit may not be adequately trained in fraud prevention and detection.

Oversight recommended the Department of Social Services – Division of Medical Services provide training in fraud detection and prevention for the SURS unit. Through attrition, DOS should consider hiring more experienced and trained staff, such as certified fraud examiners, to further increase the effectiveness of the SURS unit in the prevention and detection of fraud.

Status:

Not implemented. See Chapter 2, Comment # 3. The Department of Social Services stated, in addition to training at the time of hiring, employees receive refresher training periodically. Frequently, staff receives in-house training on traditional fee-for-service, Medicaid program policy, rules and regulations changes. There has been an established feedback loop between Program Integrity staff and Program Operations staff. The staff receives extensive training on the use of the Medstat fraud detection system, software and data analysis of management reports produced from the available fraud detection system. All training is referenced in the Program Integrity staff training logs for calendar years 2001 – 2004 to date previously provided. The division continues to seize every opportunity that is afforded during budget constrained years for training of Program Integrity staff.

Comment # 4

The Missouri Medicaid Program could be using resources more effectively in the detection and prevention of fraud.

Oversight recommended the Department of Social Services should, in conjunction with the Medicaid Fraud Control Unit and any other appropriate agencies, undertake a comprehensive evaluation of the distribution of statewide resources dedicated to curtailing fraud and abuse. Oversight recommended the Department seek the approval of the General Assembly for federal fund leveraging through the appropriation process.

Status:

Implemented. The Department of Social Services stated they received approval from the Centers of Medicare and Medicaid for the design, development and implementation of a new fraud abuse detection (FAD) system as a component "improvement" to the State's Medicaid processing and reporting system at 90% development match and 75% equipment, software and operations match. A five year contract, with the sole option to renew two additional one-year periods, was awarded to Medstat on March 22, 2002. The core of Medstat's FAD System is Medstat Advantage Suite for Fraud®, a comprehensive, multi-functional solution for identification and investigation of fraud, abuse and waste. The decision support applications, which are designed specifically for healthcare management, can be run against the entire database or any subset defined by users, enabling them to "zoom up" or "drill down" into the database. The new system is currently in the implementation and testing phase. DOS anticipates the acquisition of the FAD software and services will provide the Program Integrity staff with a powerful tool to detect and pursue inappropriate payments and fraudulent claims.

Comment # 5

The Department of Social Services – Division of Budget and Finance is not depositing Medicaid restitution receipts and prosecution cost reimbursements received from court cases into the appropriate funds.

Oversight recommended the General Assembly encourage the Office of the Attorney General – Medicaid Fraud Control Unit and the Department of Social Services – Division of Budget and Finance to use the proper funds the General Assembly has established for restitutions and prosecution reimbursements from the successful prosecution of Medicaid fraud cases.

Status:

Not implemented. See Chapter 2, Comment # 6. Department of Social Services stated the process they use does not make use of the Medicaid Fraud Reimbursement fund. Restitution receipts are deposited directly to general revenue and the appropriate federal fund to effect the repayment to the state and the federal government for the unlawful claim. First depositing these moneys in the Medicaid Fraud Reimbursement fund adds a step to the process and works against timely and efficient repayment of the restitution to

the affected fund sources. It is the recommendation of the Division of Budget and Finance that they retain the current process as it promotes the most efficient handling of these payments.

Prosecution reimbursements have historically been and continue to be managed in the same manner as restitution payments. The federal share of any reimbursement for prosecution expenses must be returned to the federal government. When receipts are received, the federal share is deposited back to the appropriate federal fund as program income, which offsets the state's future claim for Medicaid reimbursement. By this action, the federal government is repaid its share of costs of prosecution. There are no appropriations from the Medicaid Fraud Prosecution Fund so the balance remaining after repaying the federal government is returned to the general revenue fund. The Department of Social Services does not maintain separate accounting for restitution and reimbursement payments.

Comment # 6

The Division of Medical Services is not effectively meeting the expectations of the Medicaid Fraud Program because it has not actively pursued the recovery of inappropriate payments.

Oversight recommended the Medicaid program consider its use of contingent fee arrangements to detect and recover inappropriate payments. Oversight also recommended the Department of Social Services – Division of Medical Services be more pursuant through the judicial system of overpayment of Medicaid funds to providers.

Status:

Department of Social Services stated any potential civil cases that the Division of Medical Services (DMS) is unsuccessful in collecting overpayments are forwarded to the department. In turn, the department refers the cases to the Office of the Attorney General, Governmental Affairs for any decisions of pursuit or litigation. If Governmental Affairs receives payment from the providers (either through litigation or after contacting the providers requesting payment), or determines that the Bad Debt had already been reported, or is uncollectible, they notify the division of their findings. Recoveries are sent directly to the division. Accounts Receivables are set up and recovery amounts are applied accordingly. The Medicaid Fraud Control Unit (MFCU) works with Governmental Affairs to pursue Bad Debt referrals through civil litigation. In these cases, any recoveries are paid directly to the MFCU who forwards the checks to the department and copies the division. The accounts receivables are adjusted by the amount of the recovery received via MFCU.

APPENDIX I

Schedule of Medicaid Expenditures
For the 11 years ending June 30, 2004
Unaudited

	2004	2003	2002	2001	2000
Nursing Facilities	$ 705,733,747	$ 719,173,688	$ 733,211,399	$ 744,314,764	$ 725,011,582
Hospitals	$ 795,509,292	$ 758,856,188	$ 652,410,481	$ 648,816,374	$ 590,630,867
Dental Services	$ 27,325,683	$ 20,820,302	$ 17,870,426	$ 11,222,034	$ 6,040,413
Pharmacy	$ 1,077,607,952	$ 932,961,078	$ 765,965,692	$ 675,241,930	$ 581,196,903
Physician Related	$ 282,911,491	$ 247,619,541	$ 210,383,586	$ 188,382,566	$ 168,322,084
In-Home Services	$ 313,004,311	$ 308,766,299	$ 279,075,470	$ 234,090,963	$ 194,130,317
Other Services	$ 145,363,567	$ 129,352,442	$ 106,714,711	$ 85,434,913	$ 70,807,365
Buy-In Premiums	$ 82,505,136	$ 71,031,146	$ 62,277,643	$ 55,787,795	$ 51,528,026
Mental Health Services	$ 380,874,781	$ 351,915,139	$ 329,750,784	$ 286,682,530	$ 264,752,143
State Institutions	$ 207,632,443	$ 229,917,183	$ 205,525,994	$ 204,227,676	$ 169,089,733
EPSDT Services	$ 126,716,749	$ 133,653,751	$ 125,768,565	$ 119,754,186	$ 104,222,557
Managed Care	$ 743,213,973	$ 656,244,313	$ 578,878,504	$ 447,526,388	$ 367,850,555
	$ 4,888,399,125	$ 4,560,311,070	$ 4,067,833,255	$ 3,701,482,121	$ 3,293,582,546

	1999	1998	1997	1996	1995	1994
Nursing Facilities	$ 715,053,895	$ 699,583,350	$ 633,862,789	$ 574,784,655	$ 492,866,371	$ 442,282,098
Hospitals	$ 518,471,037	$ 438,174,511	$ 429,842,403	$ 501,132,961	$ 594,942,837	$ 552,742,426
Dental Services	$ 6,039,293	$ 8,384,328	$ 10,873,597	$ 13,255,070	$ 16,413,578	$ 15,968,945
Pharmacy	$ 468,598,432	$ 374,086,933	$ 320,821,307	$ 285,069,051	$ 261,802,883	$ 227,435,397
Physician Related	$ 142,998,872	$ 125,039,701	$ 130,860,078	$ 150,281,276	$ 162,681,244	$ 158,248,529
In-Home Services	$ 160,785,429	$ 142,395,340	$ 121,883,531	$ 102,979,238	$ 84,645,143	$ 60,304,592
Other Services	$ 59,764,714	$ 46,236,831	$ 43,565,476	$ 41,664,238	$ 37,954,300	$ 32,982,045
Buy-In Premiums	$ 49,113,673	$ 46,433,024	$ 44,804,302	$ 43,479,208	$ 40,839,255	$ 34,278,539
Mental Health Services	$ 241,910,746	$ 216,884,904	$ 199,538,319	$ 185,985,094	$ 162,351,288	$ 124,141,209
State Institutions	$ 136,813,414	$ 133,704,239	$ 140,938,555	$ 142,907,684	$ 135,590,979	$ 135,377,291
EPSDT Services	$ 89,218,520	$ 70,064,458	$ 72,218,948	$ 82,097,949	$ 82,412,685	$ 54,227,684
Managed Care	$ 307,342,648	$ 51,044,813	$ 11,013,243	$ 24,531,389	$ 27,421,601	$ 14,870,859
	$ 2,896,110,673	$ 2,352,032,431	$ 2,160,222,548	$ 2,148,167,813	$ 2,099,922,164	$ 1,852,859,614

Source: Department of Social Services - Division of Medical Services

APPENDIX II

Missouri Medicaid Fraud Control Unit
National Settlement Collections
State Fiscal Years 2000 - 2004

National Settlement Provider Names	Case #	State Collected FYs 2000 - 2004	State Collected FY 2000	State Collected FY 2001	State Collected FY 2002	State Collected FY 2003	State Collected FY 2004
Abbott Laboratories	23F155	$588,831					$ 588,831
Bayer	23F171	$3,090,958					$ 3,090,958
Bayer (PHS)	24F052	$5,470					$ 5,470
Columbia / HCA	98F012	$67,390			$ 67,390		
Columbia / HCA	98F012a	$198,646					$ 198,646
Eckerd Drug	20F134	$20,686			$ 20,686		
Genetech	99F073	$255,362	$ 255,362				
GlaxoSmithKline	23F172	$1,163,589					$ 1,163,589
LifeScan, Inc.	22F125	$12,801				$ 12,801	
Medaphis	99F001	$144,702	$ 144,702				
NMC / LifeChem	99F033	$172,629			$ 172,629		
Pfizer, Inc.	23F028	$566,232				$ 566,232	
Pharmaceutical Manufacterers	98F013	$128,861			$ 128,861		
Smith/Kline Beechum Clinical Labs	95F070	$1,515			$ 1,515		
TAP Manufacterers	99F113	$764,272			$ 764,272		
Walgreen Co.	98F011	$107,342	$ 107,342				
Total National Settlement Collections		$7,289,285	$507,405	$0	$1,155,354	$579,033	$5,047,493
Other reported collections (Non-National Settlement Collections)		$1,106,029	$326,247	$299,406	$110,716	$40,906	$328,755
Total Reported Collections		$8,395,314	$ 833,652	$ 299,406	$ 1,266,070	$ 619,938	$ 5,376,248
Amount of State Ordered - Non-National Settlements (agreements and judgements awarded to the State other than from national settlements)		$3,245,159	$ 626,734	$ 157,354	$ 283,289	$ 1,179,143	$ 998,639

APPENDIX III

Office of the Attorney General - Medicaid Fraud Control Unit
General Revenue vs. Federal Fund Expenditures
For State Fiscal Years 2000 through 200

	FY 2000		FY 2001		FY 2002		FY 2003		FY 2004	
General Revenue	$ 209,966	32.68%	$ 175,013	28.15%	$ 188,282	26.86%	$ 217,436	29.02%	$ 180,292	26.94%
Federal Funds *	$ 432,596	67.32%	$ 446,753	71.85%	$ 512,753	73.14%	$ 531,813	70.98%	$ 489,032	73.06%
	$ 642,562		$ 621,766		$ 701,035		$ 749,249		$ 669,324	
General Revenue expenses at 25% (what should be)	$ 160,641		$ 155,442		$ 175,259		$ 187,312		$ 167,331	
Amount state overpaid	$ (49,326)		$ (19,572)		$ (13,023)		$ (30,124)		$ (12,961)	
Cumulative Amount state overpaid	$ (49,326)		$ (68,897)		$ (81,920)		$ (112,044)		$(125,005)	
FTE Budgeted	23.00		23.00		23.00		23.00		23.00	
FTE Actual	13.93		11.75		15.51		16.94		15.50	
Difference	9.07		11.25		7.49		6.06		7.50	

* Note: to compare this amount to the federal fiscal year federal expenditures, you must add indirect costs as well as fringe benefit amounts that would be included in other cost centers in the state budget.

APPENDIX IV

BOB HOLDEN
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
P.O. BOX 6500
JEFFERSON CITY
65102-6500

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

November 24, 2004

Mickey Wilson, Director
Legislative Oversight Division
State Capitol, Room 132
Jefferson City, MO 65101

Dear Mr. Wilson:

Pursuant to your request enclosed are the Division of Medical Services responses to comments included in the program evaluation follow-up report on the State of Missouri's efforts to combat Medicaid fraud. Comments 1, 2, 5, and 8 relate to the Office of the Attorney General and are not addressed in our response. Comment 6 relates to the Department of Social Services Division of Budget and Finance. Response to that comment will be provided directly from the Division of Budget and Finance.

Please contact Marineda "Jackie" Jung of my staff at (573) 751-3399 if you have any questions.

Sincerely,

Christine Rackers

Christine Rackers
Director

CR:jj

Enclosure

bcc: Joel Schnedler
Michael Rehagen
Jackie Jung

Comment #3: The Division of Medical Services Program Integrity Unit may not be adequately trained in fraud prevention and detection.

Response: The Department of Social Services, Division of Medical Services (DMS) continues to provide initial training at the time of hiring, and refresher training is also provided periodically. Most recently, staff have received in-house training on traditional fee-for-service, Medicaid program policy, rules and regulations changes. A feedback loop has been established between the Program Integrity (PI) staff and the Program Operations staff to keep staff abreast of any changes. Extensive training is being provided to the PI staff on the use of the new Medstat fraud detection system, software, and data analysis of management reports produced by the system. This new system will be a powerful tool for the PI staff to use to detect and pursue inappropriate payments and fraudulent claims. DMS continues to seize every opportunity that is afforded during budget constrained years for training of staff.

Comment #4. The Medicaid payment system allows providers to receive payments for billing more than 24 hours in one day.

Response: The MMIS had an edit (#194) in place that calculated the number of hours billed by providers in excess of eighteen hours in a 24 hour period. When it was discovered that the edit was not calculating correctly, the status was set to "pay" so that claims did not deny in error. These claims were then reported to Program Integrity for manual review. A system task request was initiated to correct this edit, however the edit was mistakenly not placed back in active status. Effective November 16, 2004, the edit is active and will deny any claims from providers for more than 18 hours of services in a 24-hour period.

Comment #7. The Department of Social Services – Division of Medical Services strategic plan does not include annual goals, objectives, or mention of a fraud detection and prevention program within the department or division.

Response: DMS has developed a new measure for inclusion in the Department of Social Services 2006 Strategic Plan. This measure is to increase the cost avoidance and cost savings activities by the Program Integrity Unit. The strategies for the measure includes activities associated with fraud detection and training staff in the most current fraud and abuse detection processes.

Comment #9. The Department of Social Services – Division of Medical Services has not implemented recommendations made by Centers for Medicare and Medicaid Services.

Response: DMS has not found it necessary to re-enroll in-state providers periodically to ensure they maintain program qualifications. DMS is notified by the licensure board when a provider's license is expired, suspended, or revoked. The U. S. Office of Inspector General (OIG) notifies DMS of any provider exclusions and other state agencies notify DMS when they take action on their providers. Since DMS relies on these other entities to certify the qualifications of our providers, a re-enroll process for these providers would be redundant.

Concerning the area of program policy changes, when a provider signs their agreement as a Medicaid provider, they "agree to comply with the Provider Manuals, bulletins, rules and regulations as required by the DMS and the U. S. Department of Health & Human Services." Provider Manuals are updated with any new program implementation. However, when a new service is implemented requiring an additional specialty of an enrolled provider, the provider must complete a new enrollment application or an updated application depending on the significance of the change.

BOB HOLDEN
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF BUDGET & FINANCE
221 WEST HIGH STREET
P.O. BOX 1082
JEFFERSON CITY
65102-1082
TELEPHONE: 573-751-2542; FAX: 573-751-7598

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

November 30, 2004

Mickey Wilson, Director
Joint Committee on Legislative Research
Oversight Division
State Capitol, Room 132
Jefferson City, MO 65102

Dear Mickey:

Attached you will find the Department of Social Services, Division of Budget and Finance's response to Comment #6 of the Medicaid Fraud Program Follow-Up Evaluation.

If you have additional questions, please contact me at 751-7533.

Sincerely,

Brian D. Kinkade
Director

BDK:bsb

Comment #6 The Department of Social Services – Division of Budget and Finance is not depositing Medicaid restitution receipts and prosecution cost reimbursements received into the appropriate funds.

Response: With regard to restitution recoveries, in order to make timely deposit of these collections to the appropriate federal and state accounts, the Department of Social Services suggests that its current process of depositing recoveries directly to the appropriate state and federal accounts is most expeditious. First depositing these funds in the Medicaid Fraud Reimbursement fund would require the funds to be handled a second time to accomplish the final and correct deposit of the funds. DSS believes that deposits made directly to the affected accounts can be coded in a way that will provide for complete accounting of collections to the General Assembly. DSS will create and implement use of deposit codes to accomplish this reporting.

As with restitution recoveries, prosecution cost reimbursements have historically been deposited to General Revenue and federal funds from which prosecution costs are paid. However, as recommended by Oversight, DSS will work with the Attorney General's Office to seek FY 06 appropriation authority from the Medicaid Fraud Prosecution Revolving Fund and begin to deposit the state share of prosecution cost reimbursements to this fund in a manner consistent with appropriations passed by the General Assembly.

APPENDIX V

ATTORNEY GENERAL OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
ATTORNEY GENERAL

P.O. Box 899
(573) 751-3321

November 23, 2004

The Honorable Rod Jetton
Chairman of the Joint Committee on Legislative Research
Room 117-A, State Capitol Building
Jefferson City, MO 65101

Dear Representative Jetton:

I am pleased to report that the Office of the Attorney General has completed a review of the Legislative Oversight Committee's Program Evaluation of the Medicaid Fraud Control Unit.

I commend Barbara Glover, Program Evaluator with the Oversight Division, and her staff for a thorough and professional review. I believe the citizens of Missouri will be better served because of their efforts.

I appreciate the state legislature's continued support of the Medicaid Fraud Control Unit and our missions of protecting Medicaid from fraud and Missouri citizens from abuse or neglect.

We will continue performing our important missions and I am confident the Oversight Committee's analysis and recommendations will benefit Missouri citizens by increasing the Medicaid Fraud Control Unit's efficiency and effectiveness. Please note the attached comments which provide additional information relevant to the operation of the Unit.

Sincerely,

Jeremiah W. (Jay) Nixon

RESPONSE FROM
THE OFFICE OF THE ATTORNEY GENERAL

Introduction

While the Legislative Oversight Program Evaluation focuses on Medicaid fraud, it is important to note that in addition to this responsibility, one of the Unit's primary missions is investigating allegations of abuse and/or neglect of patients receiving care through the State's medical assistance programs. During the past five Federal Fiscal Years (FFY), the Medicaid Fraud Control Unit (MFCU) has investigated more than 750 complaints of abuse, neglect, mistreatment and economic exploitation of nursing home residents and recipients of home health care.

As part of its mission to deter Medicaid fraud and assist state agencies, the MFCU has undertaken proactive measures to educate providers and state agencies about detecting and preventing fraud. For example, the MFCU worked with Department of Elementary and Secondary Education (DESE), Division of Vocational Rehabilitation and its Centers for Independent Living to identify and recover Medicaid funds that were improperly paid for services provided while the Medicaid recipient was hospitalized. This collaborative effort led to the recovery of more than $300,000 and an increased urgency by DESE and its providers to detect potential fraud. Additionally, the MFCU has arranged to receive field reports of alleged patient abuse occurring in nursing homes simultaneously with Department of Health and Senior Services, Central Registry. This has provided the MFCU with earlier notice and the ability to generate an immediate response to emerging situations.

The MFCU reaches out statewide through the Attorney General's website and a toll-free Hotline phone number. Additionally, the MFCU provides speakers to local organizations on topics such as elder abuse and neglect and is active in several state and regional groups that monitor health care fraud and nursing home abuse.

Amount Ordered v. Amount Collected

The Legislative Oversight Program Evaluation states the MFCU collected a total of $8,395,314 in fiscal years 2000 through 2004. This number reflects State only money. Inasmuch as the Missouri Medicaid program is jointly funded by the Federal and State Governments, the MFCU is tasked with recovering all Medicaid monies lost to fraud. During the past five fiscal years, the MFCU obtained judgments and settlements for recoveries of $24,374,245.28. Of that amount, the MFCU has collected $22,263,908.00. The remaining amounts are being collected. The amounts are being collected via monthly payment plans established by conditions of probation or civil judgments and settlements.

We believe that if the MFCU had original jurisdiction in prosecuting Medicaid fraud even greater success could be achieved in the amount of recoveries and number of convictions. Medicaid

fraud is a unique and often highly complex crime that frequently transcends multiple jurisdictions at both the intra and inter state levels. The MFCU makes concerted efforts to educate local prosecutors about Medicaid fraud and Section 191.900 et. seq. Because the MFCU lacks original jurisdiction to file criminal charges, successful convictions and recoveries are often dependant upon coordinating the prosecutorial efforts among various jurisdictions.

Comment #1

The MFCU was funded with federal and state funds for FFY 2000 through 2004. The nature of the federal grant and award requires the MFCU to operate in the FFY which runs from October 1 to September 30. In contrast, the rest of the Attorney General's Office runs on the State Fiscal Year (SFY) which runs from July 1 to June 30.

The Office of Inspector General (OIG) requires the MFCU to submit federal quarterly and annual financial status reports - copies of which were provided to Legislative Oversight. Legislative Oversight's position finds that for FY 2000-2004, the MFCU spent approximately $125,000.00 in excess state funds. It appears that Legislative Oversight relied on the comparison of general revenue verus federal funds expenditures for SFYs which is not the operating standard for the MFCU. For the appropriate standard, a summary of the Financial Status Reports for FFYs 2000 through 2004 appears in Appendix 1. The total federal/state monies received by the MFCU for the five years is $3,654,312.60 or 74.20% federal and $1,270,442.45 or 25.80% state. The MFCU has initiated contact with OIG, Office of Management and Policy in an effort to recover the excess amount paid by the state for the five years which totals $39,320.53, not $125,000.

Comment #2

The MFCU is moving toward full staffing and has recently hired 2 investigators and 1 auditor. Interviews are continuing for the remaining positions.

The Unit is performing well above average when compared to the MFCUs of other states. Data from The Department of Health and Human Services, Office of Inspector General for FFY 2003 indicates that the Missouri MFCU ranks 12th overall in recovery per Federal Grant Dollar (see Appendix 2 and 3) and 9th in recovery per staff member (see Appendix 4 and 5).

Comment #3

Comment 3 appears to suggest the MFCU is not conducting training. First and foremost, the MFCU is unaware of any formal or specific request for training that has not been provided upon request.

The Legislative Oversight Program Evaluation Report states, "Program Integrity has requested, but has not received, fraud detection training from the MFCU." However, per the Memorandum of Understanding, there are monthly meetings between the MFCU and Program Integrity. It is standard practice that prior to the general monthly meetings, there is a meeting with the MFCU Director and Chief Investigator and Program Integrity to discuss all potential referrals. At this meeting, the strengths and weaknesses of each potential referral are discussed. If a potential referral is not sufficiently developed, the Director and Chief Investigator suggest additional information and facts Program Integrity needs to gather before a complete evaluation of the referral can be made. If after discussion, the Director decides the referral has prosecutorial merit, he accepts the referral and it is assigned to an investigator for further investigation.

After the referral meeting, a general meeting is held during which MFCU attorneys and investigators discuss the status of all Program Integrity referrals and answer any questions Program Integrity may have. The objective of this meeting is to ensure the free flow of information and enhance the spirit of collaboration and cooperation. That spirit continues throughout the month.

Comment #5

Since 2001, the MFCU has consistently sought recovery of reasonable costs attributable to the investigation and prosecution of Medicaid fraud cases, both criminal and civil, pursuant to Section 191.905, RSMo. In criminal cases, the request for costs is made during oral argument at sentencing and does not necessarily appear in a formal pleading. In civil cases, the request for costs is made in the civil petition. Thus, in each case, criminal or civil, the MFCU requests investigative and prosecutorial costs. The costs are calculated based on attorney time sheets, investigator time logs and expenses. These time sheets, time logs and expenses are easily accessible to the MFCU attorneys via MFCU and Attorney General Office databases.

OIG guidelines demand, "when a Medicaid Fraud Control Unit enters into a civil or criminal settlement, the agreement must provide that the Medicaid program be made whole by means of restitution for both the State and Federal share before the agreement allocates monies to penalties, investigative costs or damages."

Based on this guideline, the MFCU concentrates its efforts on recovering restitution for the State and Federal governments, in an amount at least equal to that unlawfully paid to the person and a civil penalty, plus three times the amount of damages which the State and Federal government sustained because of the act of that person.

As the Legislative Oversight Program Evaluation points out, in several instances judges have denied the award of investigative and prosecution costs. Based on these prior experiences, the MFCU prosecutors have concentrated on maximizing the restitution and damages awarded. Also, as a part of the negotiations, the MFCU has adopted the position that investigative and prosecution costs may be negotiable while restitution and damages are not. This approach allows the prosecutors more flexibility in reaching settlements while still maintaining focus on the core objective of making the State and Federal governments whole.

Comment #6

As the evaluation indicates, the MFCU transmits all recovered funds to the Department of Social Services, Division of Budget and Finance identifying the monies received and advising pursuant to statutory authority into which fund they should be deposited. To the extent that DSS continues to ignore the statutory directive, the MFCU request for appropriations would be futile.

Comment #8

The MFCU's operation is strictly governed and adheres to the Code of Federal Regulations, OIG Policy Manual and Missouri Attorney General's policies and procedures.

Internally, the MFCU has developed, and is continuing to develop, protocols for addressing all areas of its activities. For example, referrals and complaints are processed using computer databases which are essentially self-explanatory with drop down menus and procedures which takes the investigator through a step by step process. Also, all referrals from Program Integrity are handled in a systematic manner. Over the past two years, the MFCU has been developing and implementing standardized procedures for handling all complaints, referrals, investigations and prosecutions, just as the Legislative Oversight Program Evaluation suggests. The goal of this effort is to establish systems which will function efficiently and effectively regardless of staff turnover. The MFCU makes every effort to inform its employees of personnel and unit policies.

MISSOURI MFCU GRANT EXPENDITURE

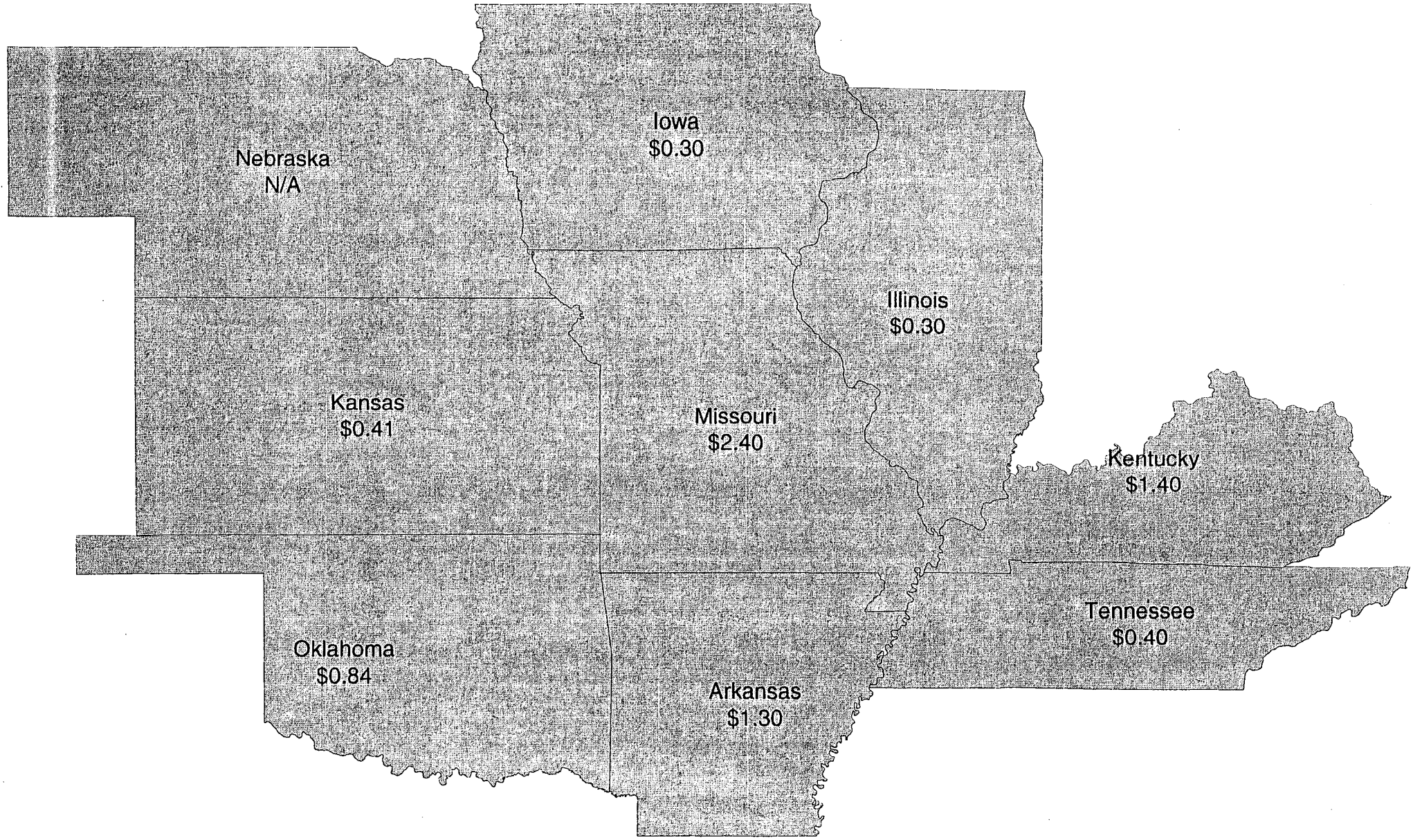
	FFY 2000	FFY 2001	FFY 2002	FFY 2003	FFY 2004	Total
State Share	$257,642.32	$235,598.45	$267,528.88	$259,062.03	$250,610.77	$1,270,442.45
Federal Share	$665,777.49	$691,309.96	$802,586.64	$748,231.27	$746,407.24	$3,654,312.60
Total Cost	$923,419.81	$926,908.41	$1,070,115.52	$1,007,293.30	$997,018.01	$4,924,755.05
State %	27.90%	25.42%	25.00%	25.72%	25.14%	25.80%
Federal %	72.10%	74.58%	75.00%	74.28%	74.86%	74.20%
Excess State Share	$26,779.17	$3,893.02	$0.00	$7,252.51	$1,395.83	$39,320.53

The State and Federal match is based on Federal Fiscal Year, not State Fiscal Year. The state overpaid less than one percent of the Medicaid Fraud Control Unit total cost over a 5 year Federal Fiscal Year period.

FEDERAL FISCAL YEAR 2003
RECOVERY PER GRANT DOLLAR

RANK#	STATE	FEDERAL GRANT AWARD	STAFF	RECOVERIES	RECOVERY PER GRANT DOLLAR
1	New Jersey	$2,170,000	36	$42,646,504	$19.65
2	Texas	$2,811,000	43	$31,043,055	$11.04
3	D. C. Unit	$1,244,000	16	$13,048,538	$10.49
4	North Carolina	$1,773,000	26	$14,077,280	$7.94
5	Virginia	$1,979,000	27	$15,619,468	$7.89
6	West Virginia	$737,000	15	$3,625,833	$4.92
7	Montana	$469,000	8	$1,270,834	$2.71
8	New Hampshire	$520,000	8	$1,399,777	$2.69
9	California	$16,158,000	189	$39,382,986	$2.44
10	Florida	$8,646,000	127	$20,983,473	$2.43
11	Hawaii	$988,000	15	$2,386,459	$2.42
12	Missouri	$1,388,000	17	$3,332,441	$2.40
13	Massachusetts	$1,991,000	24	$4,476,733	$2.25
14	Alabama	$766,000	10	$1,644,739	$2.15
15	Louisiana	$1,586,000	29	$3,396,623	$2.14
16	Maine	$366,000	5	$733,749	$2.00
17	Michigan	$3,513,000	33	$6,548,997	$1.86
18	Wisconsin	$902,000	9	$1,537,679	$1.70
19	South Carolina	$911,000	13	$1,534,659	$1.68
20	Ohio	$2,799,000	38	$4,714,459	$1.68
21	Minnesota	$1,114,000	11	$1,629,817	$1.46
22	Indiana	$2,376,000	44	$3,319,014	$1.40
23	Kentucky	$1,199,000	17	$1,673,960	$1.40
24	Pennsylvania	$3,683,000	50	$5,036,300	$1.37
25	Arkansas	$1,560,000	21	$2,029,782	$1.30
26	Oregon	$963,000	12	$1,238,106	$1.29
27	New Mexico	$842,000	13	$896,674	$1.06
28	Mississippi	$1,668,000	24	$1,659,210	$0.99
29	Vermont	$467,000	8	$459,657	$0.98
30	Washington	$1,676,000	16	$1,535,116	$0.92
31	Connecticut	$772,000	9	$699,544	$0.91
32	Oklahoma	$895,000	17	$755,969	$0.84
33	Georgia	$3,373,000	56	$2,741,904	$0.81
34	Wyoming	$325,000	4	$262,371	$0.81
35	New York	$30,624,000	295	$24,387,578	$0.80
36	Utah	$754,000	9	$539,628	$0.72
37	Maryland	$1,503,000	20	$966,922	$0.64
38	Colorado	$824,000	11	$501,448	$0.61
39	Arizona	$936,000	13	$550,567	$0.59
40	Nevada	$1,055,000	13	$544,708	$0.52
41	Kansas	$750,000	7	$304,658	$0.41
42	Tennessee	$2,156,000	35	$860,724	$0.40
43	South Dakota	$241,000	5	$94,782	$0.39
44	Iowa	$610,000	8	$183,588	$0.30
45	Illinois	$5,681,000	72	$1,679,685	$0.30
46	Delaware	$863,000	14	$254,400	$0.29
47	Rhode Island	$711,000	10	$170,046	$0.24
48	Alaska	$493,000	5	$101,217	$0.21

SURROUNDING STATES COMPARISON
RECOVERY PER GRANT DOLLAR
FEDERAL FISCAL YEAR 2003



FEDERAL FISCAL YEAR 2003
RECOVERY PER STAFF MEMBER

RANK#	STATE	FEDERAL GRANT AWARD	STAFF	RECOVERIES	RECOVERY PER STAFF MEMBER
1	New Jersey	$2,170,000	36	$42,646,504	$1,184,625
2	D. C. Unit	$1,244,000	16	$13,048,538	$815,534
3	Texas	$2,811,000	43	$31,043,055	$721,932
4	Virginia	$1,979,000	27	$15,619,468	$578,499
5	North Carolina	$1,773,000	26	$14,077,280	$541,434
6	West Virginia	$737,000	15	$3,625,833	$241,722
7	California	$16,158,000	189	$39,382,986	$208,376
8	Michigan	$3,513,000	33	$6,548,997	$198,454
9	Missouri	$1,388,000	17	$3,332,441	$196,026
10	Massachusetts	$1,991,000	24	$4,476,733	$186,531
11	New Hampshire	$520,000	8	$1,399,777	$174,972
12	Wisconsin	$902,000	9	$1,537,679	$170,853
13	Florida	$8,646,000	127	$20,983,473	$165,224
14	Alabama	$766,000	10	$1,644,739	$164,474
15	Hawaii	$988,000	15	$2,386,459	$159,097
16	Montana	$469,000	8	$1,270,834	$158,854
17	Minnesota	$1,114,000	11	$1,629,817	$148,165
18	Maine	$366,000	5	$733,749	$146,750
19	Ohio	$2,799,000	38	$4,714,459	$124,065
20	South Carolina	$911,000	13	$1,534,659	$118,051
21	Louisiana	$1,586,000	29	$3,396,623	$117,125
22	Oregon	$963,000	12	$1,238,106	$103,176
23	Pennsylvania	$3,683,000	50	$5,036,300	$100,726
24	Kentucky	$1,199,000	17	$1,673,960	$98,468
25	Arkansas	$1,560,000	21	$2,029,782	$96,656
26	Washington	$1,676,000	16	$1,535,116	$95,945
27	New York	$30,624,000	295	$24,387,578	$82,670
28	Connecticut	$772,000	9	$699,544	$77,727
29	Indiana	$2,376,000	44	$3,319,014	$75,432
30	Mississippi	$1,668,000	24	$1,659,210	$69,134
31	New Mexico	$842,000	13	$896,674	$68,975
32	Wyoming	$325,000	4	$262,371	$65,593
33	Utah	$754,000	9	$539,628	$59,959
34	Vermont	$467,000	8	$459,657	$57,457
35	Georgia	$3,373,000	56	$2,741,904	$48,963
36	Maryland	$1,503,000	20	$966,922	$48,346
37	Colorado	$824,000	11	$501,448	$45,586
38	Oklahoma	$895,000	17	$755,969	$44,469
39	Kansas	$750,000	7	$304,658	$43,523
40	Arizona	$936,000	13	$550,567	$42,351
41	Nevada	$1,055,000	13	$544,708	$41,901
42	Tennessee	$2,156,000	35	$860,724	$24,592
43	Illinois	$5,681,000	72	$1,679,685	$23,329
44	Iowa	$610,000	8	$183,588	$22,949
45	Alaska	$493,000	5	$101,217	$20,243
46	South Dakota	$241,000	5	$94,782	$18,956
47	Delaware	$863,000	14	$254,400	$18,171
48	Rhode Island	$711,000	10	$170,046	$17,005

SURROUNDING STATES COMPARISON
RECOVERY PER STAFF MEMBER
FEDERAL FISCAL YEAR 2003